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ABSTRACT

Current modes of implementing evaluation and accountability procedures can be examined with respect to their implications for the three aspects of the community psychology approach and the delivery of community mental health services: indirect services (consultation, community education, and prevention), supervision and training of caregivers, and direct services. The relationship of evaluation and accountability procedures to program development is a bi-directional one, and some of the consequences of present evaluation and accountability practices may be of mixed, or even negative, value. Specific actions available to the community psychologist that might result in a greater correlation between the development of evaluation and accountability mechanisms and acceptance of the community psychology approach include such strategies as remaining associated with the formal community mental health system or participating as an evaluator for nonestablishment community systems that have arisen independent of the formal CMHC system. (Author)

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# Some Implications of "Evaluation" and "Accountability" for the Practice of Community Psychology

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# Some Implications of "Evaluation" and "Accountability" for the Practice of Community Psychology

Ours is an age of evaluation and accountability for community-based programs, as such programs face continuous scrutiny by consumer groups, regulatory bodies, and funding sources. It is the major thesis of the present paper that the manner in which the terms "evaluation" and "accountability" are operationalized has serious implications for the delivery of community mental health services and the practice of community psychology -- implications which may paradoxically run counter to the generally positive semantic differential characteristics which we are likely to ascribe to these terms and which may militate against the development of programs based upon the community psychology paradigm. This paper will attempt to examine some of these implications with respect to salient aspects of the community psychology model[1] and of community mental health services, in particular a) indirect services (consultation, education, and prevention); b) supervision and training of caregivers; and c) direct services.

## Consultation, Education, and Prevention

Consultation and education (C and E) activities are referred to by community mental health centers (CMHCs) as "indirect" services in that the immediate targets of such activities are community groups, professional and nonprofessional caregivers, and the like, rather than clients seeking "direct" services

(e.g., therapy or counseling). (In the present paper CMHC refers to community mental health agencies in a generic sense rather than just to federally funded ones.) C and E activities have historically been regarded as important by community psychologists because of their potential for a) fostering prevention and early intervention and building in strengths and b) intervening at levels above the individual and small group (Jason & Glenwick, in press-a, in press-b). However, the current system of reimbursement by public and private funding sources may hinder the expansion of such activities. For example, county mental health boards, which exert considerable control over the allocation of funds, will contract with CMHCs mainly for direct services. This occurs for a variety of reasons, including a) the recommendations of state and other governmental bodies (Neigher, 1979), b) the lack of a vocal constituency for prevention and other community-oriented programs, c) the public's definition of the role of CMHCs, and d) the relative difficulty of evaluating indirect services (compared to evaluating direct ones). Thus funding bodies may concentrate on purchasing, and CMHCs on delivering, what they can easily evaluate and establish accountability for (e.g., direct services) rather than evaluate what they could be purchasing and delivering (e.g., perhaps more indirect and preventive services).

Though the evaluation of direct services may be more straightforward, CMHCs may at times need to be reminded that C and E activities serve several useful and/or traditional

purposes in addition to prevention and early intervention. These purposes include a) helping an agency establish visibility and viability, b) promoting the passage of mental health levies, and c) generating direct service referrals. (With respect to this last goal, it might be noted that while ideally C and E activities will reduce, over the long term, the number of persons requiring therapy and assessment, the actuality ironically is often an increase in requests for direct services, at least in the short run.) Commenting on the role of C and E in CMHCs, Borus (1978, p. 1031) has appropriately noted:

> Publicly funded CMHCs should also continue to devote some of their resources ... to consulting with community care givers, and undertaking prevention/education programs to avoid citizens' stigmatizing perception of them as 'community mental illness centers' to be used only as a last resort.

Since C and E activities are not reimbursed by as many funding sources (e.g., third party payers such as insurance companies) as are direct services, to survive they require support from public monies. For this support to continue and expand, there is a pressing need for a) the development of improved evaluation and accountability procedures; b) the dissemination of those procedures that we already possess for evaluating C and E services -- e.g., behavioral observations, surveys, rating scales, and unobtrusive nonreactive measures -- for both direct recipients of these services (e.g., consultees)

and ultimate targets (e.g., persons or systems impacted upon by consultees) (e.g., Cowen, 1978; Heller & Monahan, 1977; Jason & Ferone, 1978); and c) the development of more potent reimbursement and reinforcement mechanisms.

With respect to this last-mentioned need, an agency's direct services may receive monetary reinforcement from its funding bodies while its indirect services receive only verbal encouragement (as is the case for several community settings with which the present author is acquainted). In the face of such a reward system and the pressures of maintaining a financially sound agency, it becomes difficult to actively pursue one's ideological commitment to consultation, community education, and prevention. One way for a community-oriented administrator to effect change in such a system is to a) attempt to educate one's funding sources (e.g., the members of the county's community mental health board) as to the benefits (e.g., as outlined above) of engaging in consultation, community education, and prevention and b) if successful in this educational process, to then contract with these funding sources to deliver a specified number of units (e.g., hours) of indirect services over the course of the fiscal year (or whatever the term of the contract may be), just as one agrees to provide x units of direct services.

## Supervision and Training of Caregivers

### Quality Assurance

In recent years such mechanisms as a) quality assurance and b) licensure and certification have proliferated, ostensibly to

enhance the evaluation and accountability of services to the public. "Quality assurance" -- a process mandated by federal community mental health legislation, the Joint Commission on the Accreditation of Hospitals, and an increasing number of other regulatory agencies -- refers to the "systematic... assessing [of] the quality of services and the appropriate utilization of facilities and services" (Glossary of Quality Assurance Terms," Note 1, p. 3). The primary goals of quality assurance activities are twofold -- a) the assurance of the adequacy and appropriateness of care and b) the containment of costs by providing services that are necessary and nonoverutilized (Woy, Lund, & Attkisson, 1978). Unlike program evaluation, which tends to have a more general level of analysis (e.g., the effectiveness of a type of service or a given program), quality assurance is a form of evaluation in which the unit of analysis is usually the individual client (Woy et al., 1978).

Two of the core components of the quality assurance process are termed "utilization review" and "peer review." Utilization review is concerned with clients' needs in relation to available resources and generally addresses such questions as: Does a particular client fit the admissions criteria of our agency? Is the length of time this client has been involved with our agency justified? Are continued treatment and/or additional services for this client desirable and warranted? In peer review, professionals typically review the client treatment plans and progress notes of other mental health professionals (sometimes

just those within their own profession) to assess whether a suitable treatment approach for a client has been designed and implemented in a manner consonant with what is known about the presenting behavioral disorder and its amelioration. Thus the principal question asked in the peer review process is: "Does [the] care rendered meet currently accepted standards" for a client displaying a particular "manifest symptomatology and level of functioning" (Woy et al., 1978, p. 430)? Cases involving deviations from such standards constitute the major concern of peer review committees.

Quality assurance (and its components) is a mechanism that has been borrowed from "acute inpatient services in general hospitals" and in which "criteria sets are developed for specific diseases or disorders" (Nelson, 1979a, p. 38). Given the nature of psychological distress and our present knowledge of appropriate psychological interventions, though, the pertinence to mental health of such medical model modes of quality assurance is questionable (Nelson, 1979a, 1979b). In addition, since personnel (both professionals and paraprofessionals) from a variety of disciplines often perform the same activity (e.g., counseling or psychotherapy) in a given community setting, the desirability of each profession developing its own set of standards for peer review would appear to be of doubtful value (Goldstein & Cohen, 1975).[2]

Furthermore, one may wonder how such evaluation mechanisms influence our view of behavior problems and their amelioration.

One likely result of the prevailing manner of operationalizing the concept of quality assurance is that the presenting problems brought by a client to a CMHC are seen as a) circumscribed illness or disorder entities which b) are amenable to treatment only by a certified professional. This approach would thus contain the seeds of potential conflict with strategies characteristic of the community psychology model, e.g., the use of paraprofessionals and the provision of crisis intervention to persons not evidencing crystallized dysfunction.

Licensure and Certification

Similar inferences may be drawn from consideration of the probable impact of the present emphasis on, and procedures for operationalizing, the licensure and certification of service providers. In addition to the issue of the validity of the licensing procedure (given its reliance upon paper and pencil examination and candidates' background data), issues concerning the effect upon the efficacy of service delivery arise as well. For example, in Ohio current regulations of the State Board of Psychology permit "psychological interventions" to be conducted only by persons who have received graduate training in the appropriate techniques and who are directly supervised by a licensed psychologist (Ohio State Board of Psychology, 1977). Thus, under a strict interpretation of the regulations, vertical supervision models[3] and such "psychological interventions" as crisis counseling -- especially when utilizing undergraduates and other paraprofessionals -- might often be ruled to be unau-

thorized activities (Glenwick & Stevens, in press). Such restrictions would obviously place limitations upon the use of a) certain forms of personpower (e.g., paraprofessionals) that have often been found to be as, or more effective, than professionally delivered therapy (Durlak, 1979) and b) models of training and supervision (e.g., vertical or umbrella supervision) that might expand the scope of service delivery and the role and functions of the doctoral level professional.[4]

Despite these concerns, quality assurance and licensure per se do not seem insurmountable barriers to, and might in fact be employed to foster, the development of services derived from a community psychology paradigm. Rather than being forced into a narrow medical model mold, quality assurance could be conducted so as to yield data of value to CMHCs concerning their programs. Nelson (1979a, p. 39), for instance has suggested that utilization review can be defined broadly to permit centers to "investigate problems in utilization of the total center's resources" and to explore such questions as the "use of the center by different census tract populations." This interpretation of quality assurance and utilization review complements, or balances, the existing emphasis upon individual clients with attention to programs and to patterns of service and care for groups and communities.

Such a broad interpretation might appear to border upon (or conflict with) some of the traditional concerns of "program evaluation" -- e.g., analysis of resource utilization, program

effectiveness, efficiency, and outcome. This is a reflection of the fact that "data ... available as a result of implementation of both procedures [i.e., quality assurance and program evaluation] have synergistic consequences when applied in combination ..., with program evaluation data [having] implications for clinical decision making just as [quality assurance] results have implications for decisions concerning programs" (Woy et al., 1978, p. 439). Two points to be emphasized here are: a) At their fringes, the line between quality assurance and program evaluation becomes a somewhat arbitrarily drawn one. b) The present discussion should not be construed as advocating the elimination, or downplaying the importance, of monitoring and renewing individual clients and cases -- which, after all, forms the bedrock of quality assurance. It is, however, advocating the expansion of our conceptualization of quality assurance to incorporate supraindividual levels of analysis. This approach would enable community agencies "to meet ... [or] to modify ... government guidelines [for quality assurance] without varying too far while also providing data in a form useful for staff and center administration" (Nelson, 1979a, p. 39). In this manner both local needs and governmental mandates could hopefully be satisfied.

A correspondingly flexible interpretation of peer review would consider all service deliverers in a given agency -- from doctoral level personnel to paraprofessionals -- to be peers at least in the sense of being able to a) provide assistance to

persons in distress and b) contribute to discussion of the appropriateness and effectiveness of services offered. This approach would more accurately reflect the similarity of the services delivered by the various professions (and paraprofessionals) in a given setting, as well as the multidisciplinary and team nature of much community mental health service. Establishing criteria of care that are based on "functional and/or problem-oriented criteria," rather than on diagnoses of disease or psychopathology, might be one way of achieving a common language among all participants in the peer review process (Woy et al., 1978). A greater focus on observable and measurable data (for both client behaviors and CMHC intervention plans) may also hasten the compilation of a more reliable and valid knowledge basis than we now possess, and thus the creation of more meaningful criteria of care and service (Nelson, 1979a, 1979b).

Similarly, a focus upon service deliverers' actual competencies and helping behaviors, rather than upon secondary credentials, might enhance the accountability of those serving the public more than current licensing procedures (and regulations derived therefrom) do. Illustratively, Koocher (1979, p. 701) has suggested, as a means of evaluating service deliverers, that greater use be made of the "assessment center methodology," which focuses on the "observation of behavior in standardized performance situations."

## Direct Services

Recognizing the importance of evaluation and accountability,

as well as their financial cost, Public Law 94-63 -- the Community Mental Health Centers Amendments of 1975 -- mandates that federally funded CMHCs devote to such activities at least 2% of their previous year's total operating expenses. This 2% obligation can include all phases (e.g., planning, conducting, reporting) of evaluations by agency staff, as well as evaluations carried out by citizen or consumer groups on CMHC-related issues or services ("Guidelines for Program Evaluation in CMHCs," 1977). It is noteworthy that the federal guidelines comment that "most centers will find that the effective accomplishment of both the program evaluation for program improvement ... and the utilization and peer review for quality assurance ... will require more than 2% of ... operating expenses. This obligatory figure ... is specified as a minimum level" ("Guidelines for Program Evaluation in CMHCs," 1977, p. 34).

Like federally funded CMHCs, most community agencies (both mental health and other) are facing growing requirements for evaluation and accountability. Unfortunately, unlike federally funded CMHCs, these community agencies often have funding sources and regulatory bodies that do not provide or mandate sufficient money and time to do a first-rate job. With little extra money or staff budgeted for these activities, time must then frequently be taken from other services -- including client and community services -- performed by agency staff. Thus the snowballing demands for evaluation and accountability, in combination with finite resources to adequately carry them out, can actually pro-

duce a decrease in the quantity and quality of agency services (and an accompanying increase in the cost of delivering each unit of service). The problem has been succinctly described by Neigher (1979, p. 13) as one of "[trying] to do more with less." The point being made here is not that agencies should abandon or sacrifice evaluation and accountability activities in order to maintain current levels of other client and community services. Rather, community psychologists and evaluation specialists need to advocate and lobby for the allocation of an appropriate funding level so that evaluation and accountability can be performed properly and well. (Investigating and comparing various ways of accomplishing this goal of advocacy for evaluation could itself be a valuable community psychology endeavor.) While, in the short run, calls for evaluation and accountability will necessitate increases in expenditures, ultimately it may hopefully be demonstrated that the result of the evaluation of program and service effectiveness can be the saving, or better usage of seemingly ever-scarcer human service monies.

## General Conclusions and Suggestions

In summary, "evaluation" and "accountability," as now implemented, may not be as clear-cut forces for good as they might appear at first glance. This is true not only for the "pseudo-accountability" and "pseudo-evaluation" (i.e., cosmetic and sham evaluations) that exist all too widely in mental health and human services today, but also for honest, well-intentioned efforts at evaluation and accountability that are operation-

alized within a medical model perspective of service delivery. Additionally, the relationship of "evaluation" and "accountability" to program development is a bi-directional one -- a consideration which may often be overlooked. That is, not only do our programs determine which forms of evaluation and accountability are appropriate, but the evaluation and accountability mechanisms we adopt shape and mold the types of programs we design. Thus, implementing evaluation and accountability procedures in a community setting may be viewed, in a sense, as introducing an intervention into a system. Such an intervention, like all interventions, may have unintended second-order consequences of mixed or negative desirability which warrant attention and investigation in their own right (Willems, 1974). We need to ask ourselves if we are truly doing good and, if so, for whom -- government bureaucracies? community agencies? administrators and staff? consumers? particular segments of the community?

At points in this discussion, specific suggestions have been offered as to how evaluation and accountability procedures might be employed to promote, rather than hinder, the dissemination of a community psychology approach. Given the current state of evaluation and accountability in mental health services (as described in this paper), however, the broader options and strategies available to the community-oriented psychologist also merit exploration. One route is to remain associated with the formal community mental health system, encouraging reform and

systems change from within by pointing out the consequences (both unintended and intended) of various practices and by advocating mechanisms that foster the adoption of a community psychology paradigm (as per the suggestions offered above). In this position, while remaining understanding of and empathetic to the needs of the "system," one can attempt to offer new (and hopefully more effective) strategies of service delivery and evaluation and alternate ways of conceptualizing behavioral disorders, their causation, and their treatment. A second option is to participate as evaluator, consultant, trainer, etc. to the nonestablishment community systems -- e.g., self-help groups, neighborhood networks -- that have arisen independently of, or in opposition to, the formal CMHC system. The former position would appear to represent a combination of the perspectives of Brodsky's (1972, p. 50) "system-professional" and "system-challenger" -- one who can "mentally step outside the system to gain objectivity, and yet remain within it," -- while the latter stance corresponds more closely to that of the "system-challenger." The comparative long-run effectiveness, in terms of systems change, of these (and other) options, however, probably "depends as much upon the skills, capabilities, and beliefs of the individual involved" (Brodsky, 1972, p. 50) as upon the role he/she assumes.

In recent writings on evaluation, a distinction has been drawn between a) the "merit," or intrinsic value, of a product or entity and b) its "worth" or "value," i.e., extrinsic value

within a particular context (Scriven, 1978; Guba & Lincoln, Note 2). This distinction would seem applicable to the concepts of "evaluation" and "accountability" themselves. Community psychologists would probably agree that these concepts have "merit." Whether, in the current context of community mental health practice and with respect to the advancement of community psychology, they also possess "worth" is a subject meriting, and worthy of, consideration.

## Reference Notes

1. Glossary of quality assurance terms. Columbus, Ohio: Office of Community Standards, Ohio Department of Mental Health and Mental Retardation, July 1978.
2. Guba, E. G., & Lincoln, Y. S. The distinction between merit and worth in evaluation. Paper presented at the Fifth Annual Conference of the Evaluation Network, Cincinnati, September 1979.

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## Notes

[1]The author recognizes that to refer to the community psychology approach or model may represent somewhat of an oversimplification, in that the discipline encompasses a diverse range of activities and concepts. However, it is felt that the operations, roles, and constructs cited in this paper as falling under the community psychology rubric are ones which are almost universally agreed upon by leading theoreticians and writers in the field (e.g., Cowen, 1973; Heller & Monahan, 1977; Rappaport, 1977) as constituting integral components of the community psychology paradigm.

[2]For a more complete discussion of the problems involved in developing criteria sets and review standards in mental health, the interested reader should consult Nelson (1979b).

[3]Vertical (also referred to as umbrella or hierarchical) supervision is a supervision model which, for present purposes, will be considered to contain the following salient hallmarks: "a) a minimum of three hierarchical levels of personnel ...; b) a supervision format in which a person at each level (except the top) receives supervision, on at least part of his/her caseload, from someone on a higher level and in turn provides supervision to a lower level worker; and c) a professional with formal responsibility for the activities carried out by all those beneath him/her on the hierarchy" (Glenwick & Stevens, in press).

[4] Rather than be presented here with a repetition of the arguments for and against licensure and certification, the interested reader is referred to such sources as Gross (1978), Koocher (1979), and, with particular reference to the relationship between credentialing and community psychology, the articles in the Division of Community Psychology's special issue on the topic (e.g., Danish & Smyer, 1979; Lorion, 1979; Newbrough, 1979).